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# DEVELOPING THE OPTIMAL PROTOCOL TO AID IN ETHICAL DECISION MAKING INVOLVING TERMINALLY ILL PATIENTS AT WOMACK ARMY COMMUNITY HOSPITAL

A Graduate Research Project
Submitted to the Faculty of
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Requirements for the Degree
of
Master of Health Administration



By

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This study was conducted to develop a protocol for ethical decision making involving terminally ill patients at Womack Army Community Hospital. A survey was sent to selected Army hospitals to evaluate their current systems and establish an optimal one. The problem areas identified by the survey were "Do Not Resuscitate" orders, the need for hospice services, ordinary versus extraordinary treatment, and demands to die. A need for a written, formal decision making process was identified. The author proposed formation of an Ethics Committee to distinctly make those decisions and to coordinate an ethical education program.

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# I. INTRODUCTION

## General

Hospital ethics is a topic which has been gaining increased attention. The literature is replete with articles discussing legal, ethical, and moral ramifications of hospital decision making. Newspaper and television news programs focus on ethical dilemmas daily. Deciding whether to withhold or withdraw life support systems from patients is a decision commonly faced by physicians. Questions concerning the use of human subjects for experiments must be answered. Right-to-die and right-to-life issues become more complicated with technological developments. The escalating cost of health care raises questions as to who should receive organ transplants when such procedures are so expensive. Hospitals answering these questions are legally, morally, and ethically liable for their decisions.

Federal and state governmental involvement in medical ethical decision making can be seen in the public funding of dialysis and kidney transplants, liver transplants (in some states), Baby Doe and Baby Jane Doe issues, abortions, and indirectly wherever government funds are used. In September 1983, the Veterans Administration (VA) announced a new policy authorizing the use of "no codes." This allows physicians to write "do not resuscitate" orders for terminally ill patients in VA hospitals.[1] In January 1980, the President of the United States

established a commission to study ethical problems in medicine and biomedical and behavioral research. In March 1983, the commission submitted a 500 page report entitled, "Deciding to Forego Life-Sustaining Treatment," making it the most extensive research on ethical decision making to date. One recommendation called for the establishment of an organizational element at each hospital to facilitate ethical decision making. This element is commonly identified as an Ethics Committee,[2] but is also called a Medical-Morals Committee,[3] Criticial Care Committee,[4] Prognosis Committee, Optimum Committee, Death Committee, or Ad Hoc Committee.[5] The use of an Ethics Committee is also advocated by some members of the legal community. Harold Hirsch, MD, JD, at George Washington University advises hospitals to have such a committee to reduce liability regarding withdrawal of life support equipment and "no code" orders.[6]

Presently, approximately one percent of all hospitals have an ethics committee.[7] Although the number of hospitals having Ethics Committees is small, hospitals without them recognize a need for some method to deal with medical ethical issues.[8] In those hospitals with Ethics Committees, their functions range from that of an advisory body to a binding decision-making structure. Generally, there are four types of committees, each having a different purpose.[9] These four types are:

1. Critical Care Committee: To review ethical and other values in individual patient care decisions; determining when it is appropriate to stop treatment, or rendering opinions on whether or not treatment is appropriate, reasonable, or ordinary.

2. Research Committee: To make larger ethical and policy decisions; to decide the necessary information to be disclosed for an informed consent for research and to determine whether the hospital should allow such research, even if the patient consents.

3. Counseling Committee: These are convened for the purpose of counseling and support rather than decision making. Psychologists, social workers, clergy, etc., attend to assist the patient, family, and physician in dealing with ethical issues.

4. Prognosis Committee: These are used to confirm the prognosis that no reasonable possibility exists of the patient's return to a cognitive, sapient state. These committees should not be composed of lay people, but would require qualified physicians to render an opinion.

Based upon the President's Commission on Ethics, the need for some organizational structure referred to as an Ethics Committee has been established for civilian hospitals. The same need probably exists in Army hospitals as well. This research project will assess and examine the need for a mechanism to develop a protocol for ethical decision making. Rather than address the total spectrum of medical ethics, this study will focus on managing terminally ill patients.

Conditions Which Prompted the Study

As discussed above, ethics is a current topic of great importance. Most hospitals are facing ethical dilemmas and foresee an even greater problem in the near future. Womack Army Community Hospital (WACH) is no exception. Daily decisions are made concerning ethical issues. The Army Surgeon General's policy is that directives regarding the withholding or withdrawal of life-sustaining procedures will not be accepted or honored by Army medical treatment facility personnel. This means that if a service member desires to withhold or terminate life-sustaining procedures, necessary procedures would be continued even without consent. If a non-service member patient desires to withhold or terminate life-sustaining procedures, he should be advised that an Army hospital will not be able to honor his request and that in order to effectuate his desires, a release against medical advice will have to be executed. In addition, this non-service member patient will have to make arrangements for transfer and admission to a private hospital where his desires may be followed.

Although this policy is clear, it is extremely difficult to follow. This is especially true when the patient, the family, and the physician all agree that terminating life-support systems or not performing resuscitative procedures is in the best interest of the patient from a quality of life standpoint. If WACH is to follow the Surgeon General's guidance, it must ignore the desires of many patients--active duty, dependents, and retirees. With over 80% of the deaths in the United States occurring in hospitals or other institutions, ignoring the desires of the terminally ill or dying patient is a disservice to the patient.

Problem Statement

To develop the optimal protocol to aid in ethical decision making involving terminally ill patients at Womack Army Community Hospital.

Objectives

1. To research and study the literature regarding ethical problems and decision making within hospitals.

2. To survey the incidence of ethical problems regarding death and dying issues within selected Army hospitals.

3. To survey the mechanisms currently used within selected Army hospitals to aid in ethical decision making involving death and dying.

4. To develop the optimum protocol to aid in ethical decision making involving death and dying issues at WACH.

Criteria

1. A Chi Square analysis at the 90% level of significance will be used to test the sampling error of the survey. A 50% response level to the survey questionnaire will be acceptable.

2. The optimal feasible solution must:

a. Address each problem area identified in the survey by the majority (50%) of responses received.

b. Protect the rights of the patient as outlined in the Joint Commission on Accreditation of Hospitals (JCAH) 1984 manual.

c. Comply with the North Carolina Natural Death Statutes 90-320 through 90-322 (July 1, 1977) and 1983 Amendments.

## Assumptions

That the survey responses by the Deputy Commander for Clinical Services (DCCS) and Chief, Department of Medicine, are accurate reflections of the incidences and mechanisms regarding death and dying issues at a sampled hospital.

## Limitation

This study is confined to Army hospitals within the United States. The final recommendations may be applicable to other Army hospitals. The optimal solution must be implemented within constraints of existing resources. Although this study's primary focus is on death and dying issues, it may have some applicability to other ethical issues.

## Literature Review

The amount of literature on medical ethics is remarkable; literally hundreds of articles are written monthly on some aspect of medical ethics. Limiting the scope of this study to death and dying issues within selected Army hospitals reduces the task of the literature review somewhat, but the task is still formidable. Case studies numbering in the hundreds were reviewed to provide an adequate background to the problem. It is felt that some review of important ethical issues not relating to death and dying is appropriate to better familiarize the reader with the dilemmas of ethical decision making. To summarize what is felt to be the most important or relative views on ethical decision making (particularly death and dying issues) the literature review is divided into the following main headings: issues in death and dying, ethical decision making, issues in reproduction, scarcity of resources, and human medical research.

Issues in Death and Dying

The dramatic increase in the number and proportion of older adults is and will continue to be a critical factor that hospitals must face. Meeting the needs of this older population coupled with the technological advancements in medicine will require adaptation of the health care delivery system. Advances in medical and scientific technology make it possible to keep people alive who might never have survived in the past. These advances present complex legal, ethical, and philosophical issues that must be addressed. The definition of death, "do not resuscitate" orders (DNR), ordinary vs extraordinary care, euthanasia, demands to die, the rights of patients, and the responsibility of the physician and the hospital to the patient are examples of such issues. In the next sections, these issues will be examined more closely. There are no clear divisions between these issues, therefore, some overlap will occur.

The first issue to be examined is the definition of death. When the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research convened in January 1980, it decided to take up its first Congressional mandate to develop a uniform definition of death. In July 1981, the Commission reported its conclusions in "Defining Death" and recommended the adoption of the Uniform Determination of Death Act (UDDA). It was developed in collaboration with the American Bar Association, the American Medical Association, and the National Conference of Commissioners on Uniform State Laws. The UDDA states: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions,

or (2) irreversible cessation of all functions of the entire brain, including the stem, is dead. A determination of death must be made in accordance with accepted medical standards."[10] This report is a landmark document with far-reaching medical, ethical, and legal implications. It is a summary of currently accepted medical practices for the determination of death. The importance of a legal definition of death aids mainly in the procurement of donor organs to be used in transplantation. Other than for this purpose, it appears a legal definition of death is of little help in the resolution of these problems. Determining incompetence or withdrawing or withholding life support systems cannot be resolved using these definitions unless total cessation of brain functions can be diagnosed.[11] However, the magnitude of the UDDA cannot be overstated when one sees the consensus of physicians on a common set of guidelines even though there are differences of opinion on specific aspects of the criteria. There is still no consensus on a legal definition of death between the states; however, it is hoped that the UDDA will be the adopted standard in time.

"Do Not Resuscitate (DNR)" orders are the next issue to be discussed. Resuscitation is the ability to rescue people from eminent death by restoring life-giving heartbeat and breathing. With the dramatic increases in technology, sophisticated equipment is used routinely allowing a person to live by giving an artificial heartbeat and breath. DNR orders are given in cases of terminal irreversible illness where death is not unexpected. Although its use is not technically permissible within the Army, it does occur. MAJ McNair's study indicated widespread use of DNR orders within

Army hospitals and more than 75% of Army physicians indicated a need for a policy which would allow them to legally write DNR orders. [12]

The legality of DNR orders is still very much a debate. The few legal cases that have gone to trial indicate diverse opinions. In the Dinnerstein case in Massachusetts, an appeals court held that an order not to resuscitate a "patient in the terminal stages of an unremitting, incurable illness" was appropriate. Yet in another case, the New York Attorney General's Office disapproved DNR orders being written for elderly, incompetent patients.[13] In this light, it is not surprising that the Army Surgeon General has not allowed a DNR policy. Many physicians are concerned about their liability regarding DNR orders. As one physician stated to the President's Commission:

> Older physicians are afraid of putting "do not resuscitate" down because they are afraid of being sued for making a wrong decision. The younger physicians are anxious to put a "do not resuscitate" down because they are afraid of being sued for making a wrong decision. The nurses will not act without a "do not resuscitate" because they are afraid of being sued."[14]

The ethical dilemmas regarding DNR orders center around patient autonomy, quality of life, and allocation of resources. These issues will be discussed later in the review.

The next issue is ordinary versus extraordinary treatment. Again, it is difficult to obtain a consensus opinion of the difference between them. Ordinary treatment is that which is common or the minimum treatment which is expected. Extraordinary treatment is that which is unusual or heroic. It normally involves complex, technical equipment which requires

great efforts or expense. An example of ordinary care would be the use of antibiotics while an example of extraordinary care would be the use of a respirator to facilitate breathing.[15] Again, it is apparent that the definitions are subject to interpretation. The same ethical dilemmas arise as with DNR orders: patient autonomy, quality of life, and allocation of resources.

Euthanasia is defined as the action of inducing the painless death of a person for reasons assumed to be merciful. It is legally wrong and believed by most people to be morally wrong as well. However, a strong case can be given in certain situations for justifying euthanasia, at least on moral grounds. At the end stages of some diseases, cancer for example, patients may endure unbearable pain and suffering that can only end with death. Some argue that the only morally right decision to end the life of the sufferer is euthanasia. A number of physicians believe that it is morally acceptable to experiment with drugs on people in the final stages of a terminal disease that places the patient in great risk of death. There is only a fine line between euthanasia and experimentation with dangerous drugs.[16] Legal cases involving family members in the "mercy" killing of a terminally ill patient have concluded that this form of killing is illegal, however, some sentences handed down have been light or even probated. Criminal law allows a great deal of discretion. In the case of Woodrow Collums, a Texan convicted of the shooting death of his 72-year old brother who was suffering from Alzheimer's disease, Mr. Collums was sentenced to ten years probation.

The prosecutor in the case stated:

> Personally, emotionally, I am with Woodrow Collums, in that I have three brothers; we're very close, and I'm sure that if I were in the deathbed or vice versa, one of my brothers would end my suffering. But my position in court is as a prosecutor. And there, it's not that I'm going after Woodrow Collums personally. We have to protect the interests of potential victims out there.[17]

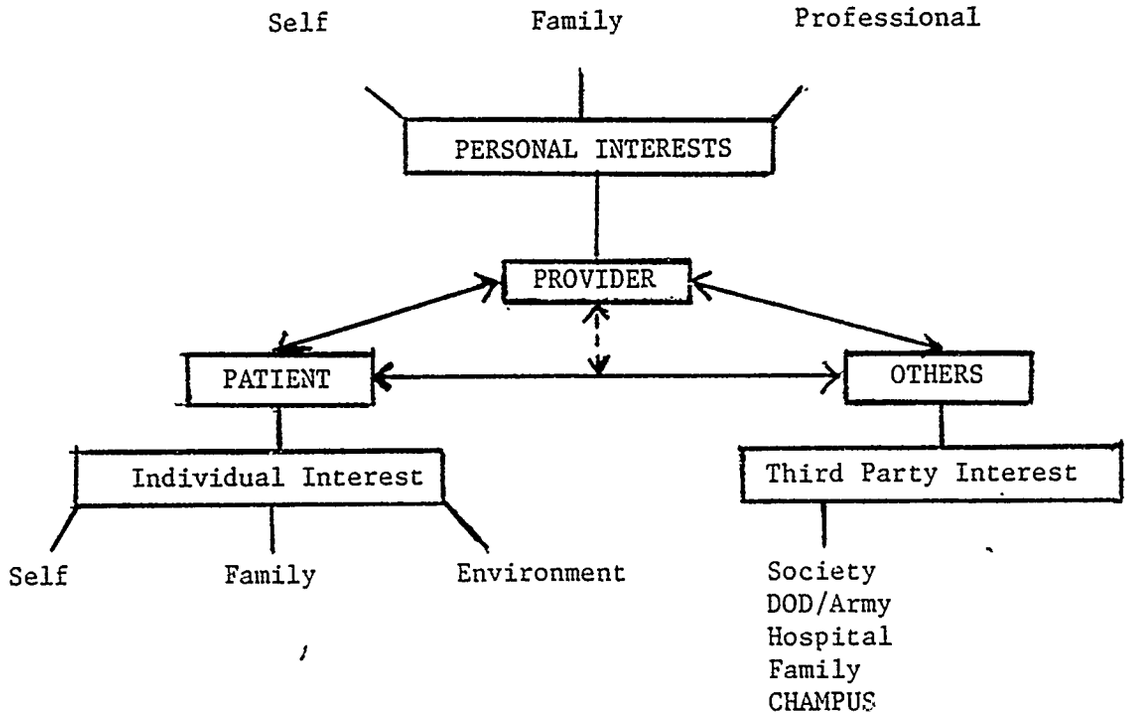
Again, the question of patient autonomy and quality of life are key issues.

The next category is demands to die. This topic is closely associated with patient autonomy and self-determination. Legally, the patient has the right to refuse treatment or to forego life sustaining procedures. Patient's rights supersede ethical considerations. The most widely acclaimed cases, Quinlan v. New Jersey, Belchertown State School v. Saikewicz, and Satz v. Perlmutter, all affirm the patients' right to refuse treatment and the right of others to effectuate the patient's refusal.[18] However, this right applies only to competent, informed patients. This opens the debate as to what constitutes being competent and informed. The health care professional has an obligation to inform the patient sufficiently for the patient to make a voluntary determination for himself. Deciding whether a patient is competent and has sufficient decision-making capacity is based on three considerations: the abilities of the patient, the requirements of the task at hand, and the consequences to the patient that are likely to flow from the decision.[19] The President's Commission outlined its view of what health professionals should ensure that patients understand:

(1) their current medical status, including its likely course if no treatment is pursued; (2) the interventions that might be helpful to the patient, including a description of the procedures involved and the likelihood and effect of associated risks and benefits; and (3) in most cases, a professional opinion as to the best alternative.[20] Many states have tried to aid in the conflict between patient autonomy and physician responsibilities by adopting living will legislation.

During the last five years, almost every state in the country has had proposed legislation dealing with "living wills" and "right to die." The common thread is the right of a competent patient to sign a declaration to reduce life-prolonging measures during terminal illness, freeing the physician from liability and the family from further anguish. The legislation stipulates that the terminal condition must be confirmed by two physicians and that the right-to-die decision is shared by the patient, physician, and family or guardian. The living will concept was pioneered in California and is described as a way to rehumanize the dying process in light of technological advances. In California, the living will can only be executed by an adult after he is diagnosed as terminally ill. Other states have removed the restriction of consent after diagnosis. Common law establishes the right to refuse treatment but without legislation there is no guarantee that the incompetent dying patient's wishes will be honored. The Society for the Right to Die has published a version that is a model for living wills. Such a document signed by the patient and witnessed by two adults may be used even by people in states without right-to-die legislation.[21]

Table 1
Ethical Dilemmas Resulting from
Conflicting Interests



Patient rights and physician responsibilities were discussed above, but what is the role of the institution in ethical decision making? Health care decision making has traditionally been the domain of the physician, however, hospitals are now being held responsible for the acts and omissions of its employees, including physicians. Hospitals have the responsibility to investigate provider credentials to ensure proper standards of medical practice. Some states require hospitals to obtain adequate documentation of informed consent. The Joint Commission on the Accreditation of Hospitals (JCAH) requires that hospitals have a policy on when informed consent must be obtained. Although the specific responsibilities that institutions have in ethical decision making is unclear, they will play an important role.[22]

Ethical Decision Making

To adopt a protocol for ethical decision making that all would agree with is nearly impossible. Particularly when the outcome, whether a patient lives or dies, is subject to debate. The real issue is to construct a logical, systematic process by which a decision is arrived upon after considering the interests of all concerned. The model diagrammed in Table 1 on the preceding page details the major parties involved; the patient, the physician, and others (family, institution, society, etc.). The interests of each party must be defined and outlined.[23] The decision making process should not dictate conclusions but provide a checklist or format to follow. Some of the problems that have arisen come from a lack of coordination and communication

between the patient and the physician or the physician and the family, or the physician and the hospital staff. Traditionally, the decision making process has been decided upon by the physician. However, physician attitudes have changed dramatically in the last twenty years. In a series of surveys between 1943 and 1961, it was found that 69-90% of the physicians routinely failed to inform their patients of a diagnosis of cancer. They felt that this knowledge would present a great burden on a patient. Using the same survey in 1978, results indicated 97% of physicians told their cancer patients of the diagnosis.[24] The interests to be considered in ethical decision making can be categorized into four areas: (1) medical indications, (2) patient preferences, (3) quality of life factors and (4) external factors.[25]

The first category is that of a determination of the medical indications. This is clearly the physician's responsibility and that of the institution for ensuring adherence to good medical standards. The physician is to make a diagnosis as to the patient's problem, to make a prognosis as to what will occur if no treatment is performed, prescribe the alternatives and the risks associated with each, and recommend his opinion of the best course of action. There is some debate as to whether the physician should give a personal recommendation since it is impossible to completely separate professional opinion from personal opinion. The persuasive power of the physician in guiding a patient to a particular choice falls into the realm of professional ethics. Physician responsibilities can be more simply stated as to providing a diagnosis, prognosis, therapeutic

alternatives, and a clinical strategy.[26] This same decision making strategy is used by other health care providers as well as nurses.[27]

The next step in the decision making process is the patient preferences. Considering patient preferences has a legal and moral base, however, it is difficult to resolve trade-offs between benefit and risk and quality and quantity of life. How does one truly assess competency when deciding to live or die?[28] This is the most difficult consideration in the physician-patient relationship. This four step decision making strategy is used in almost all physician-patient encounters and in the majority of cases patient preferences coincide with the physician's personal recommendation. However, in more difficult cases when the question of whether the patient is informed and competent and still insists on a treatment against physician advice, is when an ethical decision making protocol may be needed. It is with these more difficult cases that quality of life and external factors become important.

Most health care professionals would agree that the primary goal of health care is to maximize a patient's wellness. What is wellness or how does one measure quality of life? Answering the question, "Is this patient's quality of life as it is now or will be in the future worth treating or prolonging?" is difficult. This step often cannot be arrived at by objective criteria. Because it is most often decided by subjective opinion, the decision making process should include other health care professionals besides the physician. The nursing staff, clergy, and social workers are resources that can be included in determining the quality of life considerations.

External considerations are those that may benefit or burden someone other than the patient. They include the wishes and desires of the family, cost to society or the institution, and the safety and well-being of society. Abiding by a patient's wishes to terminate life-support systems may fulfill the patient's desires, but when the patient is gone the family is still around to sue. How much consideration should be given to family desires? Arriving at an objective conclusion is difficult but for a thorough decision making strategy to be followed external factors should be considered.

Issues in Reproduction

Scientific advances have produced ethical dilemmas in newborn care, genetic engineering, and abortions. The most prevalent issue is referred to as the Baby Doe case. In April 1982, the parents of a deformed baby, with the approval of the physician and the Indiana state court, denied the child food and a simple surgical operation to connect the child's esophagus to the stomach. The baby died and medical and legal officials agreed that Baby Doe's parents were within their rights to allow the infant to starve to death.[29] The Department of Health and Human Services (DHHS) responded that withholding or withdrawing medical care from infants could be construed by the government as discrimination against the handicapped. Further steps were taken when hospitals were directed to post a toll-free hot line number that would allow staff members to report incidents of denial of care to newborns. The issue is not fully resolved, however, DHHS has recommended that hospitals

appoint Infant Care Review Committees (ICRC) to address ethical problems.[30] Other dilemmas being faced are the ethics of genetic engineering, such as who decides what chromosome alterations can be made to the fetus, what rights does a fetus have, etc. Perhaps no other issue evokes such strong emotional outbursts as ethical dilemmas in human reproduction.

Scarcity of Resources

Perhaps the most publicized issue on allocating scarce resources was when the governor of Colorado was discussing the high cost of life support equipment and stated that terminally ill elderly people have a "duty to die and get out of the way." He went on to say, "We must ask ourselves - in a world of limited resources - does it make sense to spend $10,000 a year 'educating' a child to roll over?"[31] The issue of health care as a right is being debated as health care expenditures are reaching $279 billion a year and escalating. What costs must health care institutions pay for charity care and what role should they play in allocating resources?[32] Deciding who should receive organ transplants and who should pay for them are issues that face many hospitals. The high cost of hemodialysis to medicare patients is being debated as to whether 5% of the total medicare budget should be spent on .2% of the patients.[33] It was the intent of this section to make the point that allocating scarce resources will continue to pose ethical dilemmas for hospitals and society.

## Human Medical Research

Another issue to be mentioned briefly is the ethical dilemma of using humans in medical research. There is little debate on the need for research and even the use of human subjects. Ethical considerations arise as to the protocol and the review mechanisms to properly safeguard the rights of the human subjects. Experimenting with dosage on new drugs for the treatment of cancer may lend itself to abuse by physicians. Research on mentally incompetent patients and prisoners is common practice, what controls are needed? Protocols that are too stringent may discourage research while too lenient protocols may subvert the rights of the human subjects. Some scientists believe research in the United States is already hampered by too many restrictions. The dual allegiance of the physician and the patient and the physician and the researcher are issues that present ethical dilemmas. Again, this brief paragraph on human subjects research is added to make the reader aware of another topic in medical ethics.

## Research Methodology

The first step is a thorough literature review of hospital ethics and decision making. Library searches of books, periodicals, and research projects were made. Of great assistance was the report by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

The second step was to survey the prevalence of ethical problems in managing terminally ill patients within selected Army hospitals. An internal questionnaire was prepared and tested at WACH (Appendix B). Clinical department chiefs, chaplains, social workers, nurses, administrators, and other physicians were administered the survey for validation. Based upon the results of the internal survey, an external instrument was formulated. The internal survey results indicated that the subject of medical ethics had to be narrowed. The main focus of the study was directed toward death and dying issues. These were the subjects of greatest controversy at WACH.

An external survey was prepared to survey selected Army hospitals to determine the problems they are facing regarding death and dying issues (Appendix C). The external survey was sent to the Administrative Residents at selected Army hospitals located in the United States. The Administrative Residents distributed and collected the surveys from the Deputy for Clinical Services (DCCS) and Chief, Department of Medicine. Letters of instruction are at Appendix D.

From the interviews with the DCCS and Chief, Department of Medicine at WACH, it was determined that these individuals were the most knowledgeable of ethical issues and had the greatest input into ethical decision making. At those hospitals without an Administrative Resident, the surveys were sent to the Chief, Clinical Support Division. A list of the hospitals and their current Administrative Residents is attached as Appendix E.

The results of the external survey provided information as to the current level of awareness of ethical issues, what problems other hospitals are experiencing in managing terminally ill patients, what methods are being used in decision making, and what methods are working. The following analyses were performed and will be discussed later.

1. Homogeneity of DCCS and Chief, Department of Medicine with regard to:
    a. level of awareness
    b. problem areas
    c. present protocol
    d. rating of present protocol
    e. optimum protocol
2. Problem areas regarding:
    a. size of hospital
    b. level of awareness
    c. present protocol
3. Present protocol regarding:
    a. size of hospital
    b. level of awareness
4. Rating of present protocol regarding
    a. size of hospital
    b. present protocol
    c. optimum protocol

5. Optimum protocol regarding:

    a. size of hospital

    b. level of awareness

    c. current protocol

    d. rating of present protocol

By analyzing this data, objectives 2 and 3 were accomplished. This analysis gave insight into what is working at selected Army hospitals, and using this information coupled with the literature review, the optimum protocol was developed. The optimum protocol was the best method that is working in selected Army hospitals based upon the survey results. The ultimate goal is for Womack Army Hospital to be better able to solve ethical dilemmas with terminally patients.

# FOOTNOTES

FOOTNOTES

[1]"Health Care Industry Faces Ethical Dilemma," Federation of American Hospitals Review, Vol 16, No. 6, Nov/Dec 1983, p. 15.

[2]Abram, Morris B., Deciding to Forego Life Sustaining Treatment, Report by President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Government Printing Office, March 1983, p. 5.

[3]Bader, Sister Diana, OP, PhD, "Medical-Moral Committee: Guarding Values in an Ambivalent Society," Hospital Progress, Dec 1982, 63(12) p. 82.

[4]Cassem, Ned H., "When to Disconnect the Respirator," Psychiatric Annals, Feb 1979, p. 40.

[5]Levine, Carol, "Hospital Ethics Committees: A Guarded Prognosis," Hastings Center Report, Vol 7, No 3, June 1977, p. 26.

[6]"Establish Ethics Committee to Minimize Liability," Hospital Risk Management, Vol 3, No 4, April 1981, p. 45.

[7]Abram, Morris, B., Ibid, p. 446

[8]Ibid, p. 448.

[9]Wallace-Barnhill, George, et.al, "Medical, Legal, and Ethical Issues in Critical Care," Critical Care Medicine, Vol 10, No 1, Jan 1982, p. 60.

[10]"Deciding to Forego Life-Sustaining Treatment," President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (Washington, DC: US Government Printing Office, 1983), pp 9-10.

[11]Wallace-Barnhill, p. 15.

[12]McNair, John N. "Survey of the United States Army Physician Opinion: The Issue of Do Not Resuscitate," Graduate Research Project, August 1983.

[13]"Deciding to Forego Life-Sustaining Treatment," p. 238.

[14]"Deciding to Forego Life-Sustaining Treatment," p. 239.

[15]"Deciding to Forego Life-Sustaining Treatment," pp. 83-87.

[16]"Deciding to Forego Life-Sustaining Treatment," p. 73.

[17]"Deciding to Forego Life-Sustaining Treatment," p. 34.

[18]"Deciding to Forego Life-Sustaining Treatment," p. 38.

[19]"Deciding to Forego Life-Sustaining Treatment," p. 45.

[20]"Deciding to Forego Life-Sustaining Treatment," p. 51

[21]Raber, Patricia E., "Ethical and Legal Problems of Living Wills," Geriatrics, August 1980, pp 27-29.

[22]"Deciding to Forego Life-Sustaining Treatment," pp. 103-106.

[23]Watts, Malcolm S. M., et. al., "Ethical Problems in Medical Practice," The Western Journal of Medicine, Vol 137, No. 1, July 1982, pp. 83-86

[24]"Deciding to Forego Life-Sustaining Treatment," pp. 53-54

[25]Siegler, Mark, "Decision Strategy for Clinical-Ethical Problems in Medicine," Arch Intern Med, Volume 142, Nov 82, pp. 2178-2179.

[26]Ibid, p. 2178.

[27]Cassem, p. 392.

[28]Eraker, Stephen A. and Politser, Peter, "How Decisions re Reached: Physician and Patient," Annals of Internal Medicine, Vol 97, 1982, p. 262.

[29]Klitsch, Michael, "Mercy or Murder? Ethical Dilemmas in Newborn Care," Family Planning Perspectives, Vol 15, No. 3, p. 143.

[30]"Ethics Committees May Help Solve Hospitals' Dilemmas," Hospital Peer Review, Vol 9, No. 4, p. 45

[31]"Colorado Governor's "Duty to Die" Line Angers the Elderly," USA TODAY, 29 March 1984, p. 2a.

[32]Stacey, James, "Rationing of Care is the Debate for the '80s," American Medical News, Vol 25, No 43, 12 Nov 82, p. 22.

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## II. DISCUSSION

### Present System

WACH does not have a written or formal system for managing decision making for terminally ill patients. A Discharge Planning Committee aids in placing patients into appropriate care facilities after their treatment at WACH. These facilities include the patient's home, relative's residence, and nursing homes; skilled, intermediate, and minimal. Hospice facilities/services are not available in the immediate area. Even though the Surgeon General's policy prohibits DNR orders, withdrawing or withholding life support systems, and does not recognize demands to die, these problems cannot be ignored. Daily decisions on DNR orders are made by staff physicians. Each morning the physicians in the Department of Medicine meet to review cases that are difficult to manage. At this time, decisions are made as to treatment and care of terminally ill patients. The medical intensive care unit (MCCU) has eleven beds. Currently, two are occupied by patients that are respiratory dependent and both have been at WACH over a year. Several months ago, three beds were occupied by respirator dependent patients, but one was weaned from respirator long enough to be transferred to a Veterans Administration (VA) hospital where shortly afterwards he returned to the respirator. There are no placement facilities for respirator dependent patients, consequently, the two remaining individuals

will stay at WACH indefinitely or possibly until they die.

In addition, the male and female medical wards have terminally ill patients, mostly cancer patients, located on both wards at all times. WACH subscribes to the practice of written DNR orders. As Major McNair's study indicated, more than 75% of the United States Army physicians subscribe to an allowed written DNR policy.[1] The President's Commission also endorses a written policy that allows DNR orders. It was interesting to note that the Navy, VA, and Public Health Service allow DNR orders.[2] In order for the optimal protocol for ethical decision making concerning terminally ill patients at WACH to be developed, other Army hospitals were surveyed to determine their problems and what is or is not working for them.

Internal Survey

An internal survey was conducted in an effort to obtain an instrument that was valid and reliable. Twenty-five questionnaires were returned with eight being from physicians. From the results of the internal survey, an external survey instrument was prepared. Many lessons were learned from the pilot test. First, it was determined that the scope of the internal survey was too comprehensive. The length of an external survey needed to cover all the areas in the internal survey would be exorbitant. It was determined from the results of the internal survey that the main problem areas were concerned with death and dying issues. Therefore, the original scope of the project was narrowed.

The second lesson learned was in the wording of the questions. It was found in the responses that Questions 4 and 5 were misleading to many individuals taking the survey. As a result, the survey instrument questions were changed to be more clear and the responses more applicable to the questions.

The next lesson learned was that many of the respondents in the external survey had little or no input into the decision making process. Although the chaplains, nurses, social workers, and administrators were affected by the outcome of the decision, the actual decisions are made by the physicians. Therefore, it was decided that only physicians would be surveyed. The physicians most knowledgeable and having the greatest impact on ethical decision making at WACH are the DCCS and the Chief, Department of Medicine. The assumption was made that the responses of these individuals would be accurate reflections of the hospitals to which they are assigned. The results of the internal survey which are applicable to this study are listed in Appendix F.

Analysis of Internal Survey Results

Because of the problems in wording of the internal survey and the change in focus between the internal and external survey, this analysis will center on the eight physician responses (Appendix F). The level of awareness of death and dying issues of the physician respondents appears to be high with all but one answering in the affirmative. Question #5 stated, "I believe Womack handles the following ethical problems adequately." Only two agreed, with the remaining disagreeing or undecided. This indicates that the physicians surveyed do not believe WACH has an adequate decision making procedure. Question 7 addressed the need

for an ethics committee. Of the physician responses, five indicated a need and three indicated that a committee would "probably not" aid in the decision making process. Of the total responses for this question, 60% thought a committee would aid the decision making process while 20% said "probably not," and 20% answered "do not know." Further analysis of this survey in comparison with the external survey is examined in the last section of the discussion.

External Survey - Sampling Procedure

This survey was developed from the results and comments of the internal survey. It was designed and structured as outlined in Isaac and Michael's Handbook in Research and Evaluation.[3] The survey instrument was kept as simple as possible to increase the return rate. The questions used in the survey paralleled the objectives as discussed in the introduction. The population to be surveyed consisted of all Army hospitals within the United States. Surveys were sent to 32 Medical Centers and Medical Department Activities. Surveys were sent to the DCCS and Chief, Department of Medicine, bringing the total number of surveys sent out to 64. Based upon the criteria, a 50% return rate would have been acceptable. The actual return rate was 55 out of 64, or 86%. The high return rate was attributed to sending the majority of surveys to the Administrative Residents for them to monitor and ensure compliance. A listing of the percentage of return by hospital size is in Table 2.

Table 2
Number and Percentage of Hospitals Surveyed

| | # Sent | % Returned | % Returned | % of Total |
|---|---|---|---|---|
| Less than 50 beds | 4 | 4 | 100 | 7 |
| 50-100 beds | 16 | 12 | 75 | 22 |
| 100-200 beds | 18 | 17 | 94 | 31 |
| 200-300 beds | 8 | 8 | 100 | 15 |
| More than 300 beds | 18 | 14 | 78 | 25 |
| | 64 | 55 | 86 | 100% |

DCCS and Chief, Department of Medicine Analysis

The first area of analysis was to test homogeneity of the two different respondents. A Chi Square Analysis at the 90% level of significance was used. Homogeneity between these two respondents was calculated in each of the following areas: level of awareness, problem areas, present protocol, rating of present protocol, and optimum protocol. The areas analyzed correspond to questions 3, 4, 5, 6, and 7 and the contingency tables and the Chi Square analysis figures are shown in Tables 3-7. Although several of the expected values in the Chi Square analysis were under five which may skew the final outcome, in this case, it is appropriate since even with the skewed values the Chi Square statistic is not significant. It can be concluded that the responses of the DCCS and the Chief, Department of Medicine were homogeneous for each question surveyed.

Table 3
Contingency Table
Chi Square Analysis
DCCS/C, Med and Level of Awareness Rating

| | EXCELLENT | GOOD | FAIR | POOR/ UNSURE | TOTAL |
|---|---|---|---|---|---|
| DCCS | 10 (9.5) | 11 (11.3) | 4 (3.3) | 1 (1.9) | 26 |
| C, Med | 10 (10.5) | 13 (12.7) | 3 (3.7) | 3 (2.1) | 29 |
| Total | 20 | 24 | 7 | 4 | 55 |

Chi Square Statistic: .43
Chi Square Critical Value: 6.25
Conclusion: Homogeneous

Table 4
Contingency Table
Chi Square Analysis
DCCS/C, Med and Problem Areas

| | NO CODES | EUTHANASIA | DEFIN. OF DEATH | ORD. VS EXTRAORD. | HOSPICE SERVICES | DEMANDS TO DIE | TOTAL |
|---|---|---|---|---|---|---|---|
| DCCS | 11 (12.7) | 18 (17.0) | 22 (21.2) | 17 (16.5) | 10 (11.3) | 15 (14.3) | 93 |
| C, Med | 16 (14.3) | 18 (19) | 23 (23.8) | 18 (18.5) | 14 (12.7) | 15 (15.7) | 104 |
| Total | 27 | 36 | 45 | 35 | 24 | 30 | 197 |

Chi Square Statistic: 0.81
Chi Square Critical Value: 9.24
Conclusion: Homogeneous

Table 5
Contingency Table
Chi Square Analysis
DCCS/C, Med and Present Protocol

| | DEPARTMENT COMMITTEE | HOSPITAL COMMITTEE | AD HOC COMMITTEE | WRITTEN | UNWRITTEN | NONE OTHER | TOTAL |
|---|---|---|---|---|---|---|---|
| DCCS | 3 (1.9) | 2 (1.4) | 1 (1.9) | 5 (4.7) | 9 (11.3) | 6 (4.7) | 26 |
| C, Med | 1 (2.1) | 1 (1.6) | 3 (2.1) | 5 (5.3) | 15 (12.7) | 4 (5.3) | 29 |
| Total | 4 | 3 | 4 | 10 | 24 | 10 | 55 |

Chi Square Statistic: 3.81
Chi Square Critical Value: 9.24
Conclusion: Homogeneous

Table 6
Contingency Table
Chi Square Analysis
DCCS/C, Med and Rating of Present Protocol

| | EXCELLENT | GOOD | FAIR | POOR/UNSURE | TOTAL |
|---|---|---|---|---|---|
| DCCS | 8 (7.6) | 13 (12.8) | 4 (4.3) | 1 (1.4) | 26 |
| C, Med | 8 (8.4) | 14 (14.2) | 5 (4.7) | 2 (1.6) | 29 |
| Total | 16 | 27 | 9 | 3 | 55 |

Chi Square Statistic: 0.52
Chi Square Critical Value: 6.25
Conclusion: Homogeneous

Table 7
Contingency Table
Chi Square Analysis
DCCS/C, Med and Optimum Protocol

| | DEPARTMENT COMMITTEE | HOSPITAL COMMITTEE | AD HOC COMMITTEE | WRITTEN | UNWRITTEN | NONE/ OTHER | TOTAL |
|---|---|---|---|---|---|---|---|
| DCCS | 2 (2.4) | 7 (4.7) | 1 (2.4) | 13 (11.3) | 2 (1.9) | 1 (3.3) | 26 |
| C, Med | 3 (2.6) | 3 (5.3) | 4 (3.6) | 11 (12.7) | 2 (2.1) | 6 (3.7) | 29 |
| Total | 5 | 10 | 5 | 24 | 4 | 7 | 55 |

Chi Square Statistic: 7.25
Chi Square Critical Value: 9.24
Conclusion: Homogeneous

Surveyed Problem Area Analysis

This section examined the problem areas found in the survey and compared them with size of hospitals surveyed, the level of awareness of ethical issues, and the present protocol for ethical decision making. The results are located in Tables 8-10. Table 8 displays the percentage of hospitals having problems or unsure of problems by size of hospital.

Table 8
% of Responses Indicating Problems/Unsure
By Hospital Size

| (BED SIZE) | 50 | 50-100 | 100-200 | 200-300 | 300 | Total |
|---|---|---|---|---|---|---|
| No Codes | 25 | 33 | 59 | 62 | 64 | 51 |
| Euthanasia | 0 | 42 | 29 | 38 | 43 | 27 |
| Def of Death | 0 | 17 | 24 | 25 | 14 | 18 |
| Ord Vs Extraord | 0 | 25 | 29 | 63 | 50 | 36 |
| Hospice Need | 25 | 50 | 35 | 63 | 79 | 56 |
| Demands to Die | 50 | 33 | 47 | 50 | 36 | 45 |

This data indicated the larger hospitals have more problems managing terminally ill patients. Observing the total percentage of hospitals indicating problems and given the criteria listed in the methodology, one would conclude that the greatest problem areas lie with no code procedures and the need for hospice services.

Hospitals larger than 200 beds indicated problems exist in ordinary vs extraordinary treatment and demands to die as well as no codes and need of hospice services. WACH falls into the category of less than 200 beds, therefore, the optimal protocol should specifically address no codes, ordinary versus extraordinary treatment, need of hospice services, and demands to die.

The next area in this section compared problem areas to the level of awareness of ethical issues. Table 9 lists these observations.

Table 9
% of Responses Indicating Problems/Unsure
By Level of Awareness

| | EXCELLENT | GOOD | FAIR | POOR | UNSURE |
|---|---|---|---|---|---|
| No Codes | 50 | 58 | 43 | 100 | 100 |
| Euthanasia | 5 | 46 | 71 | 100 | 100 |
| Def of Death | 0 | 17 | 43 | 50 | 100 |
| Ord Vs Extraord | 40 | 29 | 57 | 100 | 50 |
| Hospice Need | 55 | 46 | 71 | 100 | 50 |
| Demands to Die | 25 | 46 | 71 | 100 | 50 |

The majority of the responses indicated the level of awareness of death and dying issues was good or excellent. From the results recorded in Table 9, the hospitals responding with a lower level of awareness indicated that they had more problems. The low number of responses in the fair, poor, and unsure categories prohibit the use of a statistical technique. Therefore, the above conclusion is not statistically significant but it is worth mentioning.

A comparison of problem areas and present protocol is listed in Table 10.

Table 10
% of Problems Areas by Present Protocol

| | DEPARTMENT COMMITTEE | HOSPITAL COMMITTEE | AD HOC COMMITTEE | WRITTEN | UNWRITTEN | OTHER | NONE |
|---|---|---|---|---|---|---|---|
| No Codes | 50 | 100 | 50 | 10 | 67 | 83 | 20 |
| Euthanasia | 25 | 0 | 25 | 10 | 54 | 50 | 0 |
| Def of Death | 0 | 50 | 0 | 0 | 38 | 33 | 20 |
| Ord vs Extraord | 0 | 50 | 0 | 20 | 63 | 33 | 20 |
| Hospice Need | 75 | 50 | 25 | 50 | 79 | 50 | 20 |
| Demands to Die | 25 | 100 | 25 | 10 | 54 | 83 | 40 |

By combining categories, the following results were observed:

Table 11
% Problem Areas by Present Protocol

| | Committee/Written | Unwritten/None/Other |
|---|---|---|
| No Codes | 35 | 63 |
| Euthanasia | 15 | 46 |
| Def of Death | 0 | 34 |
| Ord Vs. Extraord | 25 | 49 |
| Hospice Need | 50 | 66 |
| Demands to Die | 15 | 57 |

It appears that hospitals with a committee or written procedures have fewer problems than hospitals with unwritten/none/other procedures. A Chi Square analysis was performed combining categories. The results are in Table 12.

Table 12
Contingency Table
Problem Areas by Present Protocol

| | Committee/Written | Unwritten/None/Other | Total |
|---|---|---|---|
| No Codes | 7 (5.9) | 22 (23.9) | 29 |
| Euthanasia | 3 (3.9) | 16 (15.1) | 19 |
| Def of Death | 0 (2.4) | 12 (9.6) | 12 |
| Ord Vs. Extraord | 5 (4.5) | 17 (17.5) | 22 |
| Hospice Need | 10 (6.7) | 23 (26.3) | 33 |
| Demands to Die | 3 (4.7) | 20 (18.3) | 23 |
| Total | 28 | 110 | 138 |

Chi Square Statistic: 6.44
Chi Square Critical Value: 9.25
Conclusion: Homogeneous

Although the percentages indicated that hospitals with a committee or written procedures had fewer problems than those without, the difference is not statistically significant.

Present Protocol Analysis

In this section is an examination of the survey results of current protocols by size of the hospital and level of awareness. Table 13 details current protocol and size.

Table 13
% Present Protocol by Size

| | 50 | 50-100 | 100-200 | 200-300 | 300 |
|---|---|---|---|---|---|
| Department Committee | 0 | 17 | 0 | 13 | 7 |
| Hospital Committee | 0 | 0 | 6 | 13 | 0 |
| Ad Hoc Committee | 0 | 17 | 6 | 0 | 14 |
| Written | 25 | 8 | 28 | 25 | 14 |
| Unwritten | 50 | 50 | 24 | 25 | 50 |
| None | 0 | 8 | 24 | 0 | 7 |
| Other | 25 | 0 | 12 | 25 | 7 |
| Total | 100 | 100 | 100 | 100 | 100 |

From Table 13, the most common protocol is unwritten for all sizes except 100-200 bed facilities in which case written was the most common. The most striking feature is that in all sizes, more than 50% responded unwritten, none, and/or other.

When comparing present protocol by level of awareness, there does not appear to be any significant relationship. Table 14 displays the

Chi Square analysis which indicated that there is no significant difference in current protocols in comparison to level of awareness in the example given.

Table 14
Contingency Table
Chi Square Analysis
Present Protocols and Level of Awareness

| | EXCELLENT/GOOD | FAIR/POOR/UNSURE | TOTAL |
|---|---|---|---|
| Committee/Written | 18 (17.6) | 4 (4.4) | 22 |
| Unwritten/None/Other | 26 (26.4) | 7 (6.6) | 33 |
| TOTAL | 44 | 11 | 55 |

Chi Square Statistic: 0.4
Chi Square Critical Value: 2.71
Conclusion: Homogeneous

Rating of Present Protocol Analysis

The survey results of the ratings of the present protocols were compared to size of hospital and present protocol. The overall results are as shown in Table 15.

Table 15
Rating of Present Protocols in Percentage by Size

| | NUMBER OF BEDS | | | | |
|---|---|---|---|---|---|
| | 50 | 50-100 | 100-200 | 200-300 | 300 |
| EXCELLENT | 25 | 33 | 29 | 50 | 21 |
| GOOD | 75 | 58 | 29 | 38 | 50 |
| FAIR | 0 | 9 | 29 | 9 | 29 |
| POOR | 0 | 0 | 6 | 13 | 0 |
| UNSURE | 0 | 0 | 7 | 0 | 0 |
| TOTAL | 100 | 100 | 100 | 100 | 100 |

This data indicated that most hospitals, regardless of size, rate their present protocol good or excellent. The larger hospitals have a higher percentage with less than good ratings. The Chi Square analysis in Table 16 disclosed that the rating of present protocols by size was homogeneous, thus, the apparent difference in the lower rating by larger hospitals was not statistically significant.

Table 16
Contingency Table
Chi Square Analysis
Rating of Present Protocol by Bed Size

| | BED SIZE | | |
|---|---|---|---|
| | 200 | 200 | TOTAL |
| EXCELLENT/GOOD | 25 (25.2) | 17 (16.8) | 42 |
| FAIR/POOR/UNSURE | 8 ( 7.8) | 5 ( 5.2) | 13 |

Chi Square Statistic: 0.017
Chi Square Critical Value: 2.71
Conclusion: Homogeneous

The rating of present protocol by current protocol is depicted in Table 17.

Table 17
Rating of Present Protocol in % by Current Protocol

| | DEPARTMENT COMMITTEE | HOSPITAL COMMITTEE | AD HOC COMMITTEE | WRITTEN | UNWRITTEN | NONE | OTHER |
|---|---|---|---|---|---|---|---|
| EXCELLENT | 25 | 0 | 20 | 27 | 42 | 33 | 14 |
| GOOD | 75 | 50 | 60 | 55 | 42 | 33 | 43 |
| FAIR | 0 | 0 | 20 | 18 | 16 | 17 | 29 |
| POOR | 0 | 0 | 0 | 0 | 0 | 17 | 14 |
| UNSURE | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

From this data, there does not appear to be a current protocol that has higher ratings than another protocol. The Chi Square analysis in Table 18 shows that present protocols are homogeneous by rating.

Table 18
Chi Square Analysis
Rating of Present Protocol by Current Protocol

| | COMMITTEE/WRITTEN | UNWRITTEN/NONE/OTHER | TOTAL |
|---|---|---|---|
| EXCELLENT/GOOD | 19 (17.6) | 23 (24.4) | 42 |
| FAIR/POOR/UNSURE | 4 ( 5.4) | 9 ( 7.6) | 13 |
| Total | 23 | 32 | 55 |

Chi Square Statistic: 0.73
Chi Square Critical Value: 2.71
Conclusion: Homogeneous

Optimum Protocol Analysis

In this section, a comparison of optimum protocol by size of hospital and by current protocol is discussed. Table 19 displays optimum protocol recommendations by hospital size.

Table 19
% Optimum Protocol by Hospital Size

| | 50 | 50-100 | 100-200 | 200-300 | 300 |
|---|---|---|---|---|---|
| Department Committee | 0 | 33 | 6 | 0 | 7 |
| Hospital Committee | 0 | 17 | 12 | 50 | 29 |
| Ad Hoc Committee | 25 | 0 | 12 | 13 | 7 |
| Written | 25 | 25 | 47 | 25 | 50 |
| Unwritten | 25 | 8 | 12 | 0 | 0 |
| Other | 25 | 17 | 11 | 12 | 8 |
| Total | 100 | 100 | 100 | 100 | 100 |

The data seems to indicate that most respondents favor a written or committee protocol; however, the Chi Square analysis indicates that the data is homogeneous. Table 20 illustrates the analysis.

Table 20
Contingency Table
Chi Square Analysis
Optimum Protocol by Hospital Size

| | 200 | 200 | TOTAL |
|---|---|---|---|
| Written Committee | 24 (25.6) | 20 (17.6) | 44 |
| Unwritten/Other | 9 (6.7) | 2 (4.4) | 11 |
| Total | 33 | 22 | 55 |

Chi Square Statistic: 1.9
Chi Square Critical Value: 2.71
Conclusion: Homogeneous

The only statistically significant conclusion is comparing the recommended optimum protocol to the current protocol. Table 21 lists the differences.

Table 21
Contingency Table
Chi Square Analysis
Optimum Protocol by Present Protocol

| | OPTIMUM PROTOCOL | PRESENT PROTOCOL | TOTAL |
|---|---|---|---|
| Department Committee | 5 (4.5) | 4 (4.5) | 9 |
| Hospital Committee | 10 (6) | 2 (6) | 12 |
| Ad Hoc Committee | 5 (4.5) | 4 (4.5) | 9 |
| Written | 24 (17) | 10 (17) | 34 |
| Unwritten | 4 (14) | 24 (14) | 28 |
| None/Other | 7 (9) | 11 (9) | 18 |
| Total | 55 | 55 | 110 |

Chi Square Statistic: 26.5
Chi Square Critical Value: 9.24
Conclusion: Heterogeneous

This data suggests that most hospitals indicated that the optimum protocol is different from their current protocol. The Chi Square analysis revealed that the number of hospitals recommending an optimum protocol different from their present protocol was statistically significant.

Review of Analyses

The Tables and Chi Square analyses presented quite a large amount of data, but what conclusions can be drawn thus far? The intent of the survey was to be able to glean insight from other Army hospitals to aid in developing the optimal protocol for ethical decision making regarding death and dying issues at Womack Army Community Hospital. The only statistically significant survey response was that what other Army hospitals have as their present protocol is not what they believe to be the optimum protocol. Most hospitals rated their present protocol as good or excellent indicating satisfaction with their current system. I believe that the results are somewhat misleading. The comments given at the end of the survey suggested that most hospitals are not satisfied with their present system. Nearly 40% of the respondents indicated a need for written guidance from the Surgeon General's Office on the use of DNR orders. Nearly 25% of the hospitals commented on their procedures not being consistent with the SGO guidance. This indicated a possible reluctance to surface problem areas that would not be an

issue if strictly keeping with the SGO's guidance. The first objective of the study was to research the literature regarding ethical problems and decision making within hospitals. This has been accomplished as discussed in the introduction, except for the literature review of decision making strategies. This will be accomplished later in the study.

The second objective was to survey the incidence of ethical problems regarding death and dying issues within selected Army hospitals. This was accomplished and according to the criteria (Tables 8-12), the optimal solution must address problems identified by at least 50% of the respondents. These problems were identified as "no codes," ordinary versus extraordinary treatment, need for hospice services, and demands to die. The third objective was to survey the mechanisms currently used within selected Army hospitals to aid in ethical decision making involving death and dying (Tables 13-18). No one mechanism was statistically significant or even the combination of written and committee systems was significant (Table 21). However, the survey did indicate that the optimum protocol should be written and the second most used response was that of a hospital based committee. The next section will take the information gained from the survey and with the literature review develop the optimal protocol for WACH, thus satisfying objective four.

## Development of Optimal Protocol

The assessment of the need for some type of structure to manage ethical decision making for terminally ill patients has been established.

The survey results indicated that a written, hospital based protocol is the optimum. This was further substantiated by the literature review. The Baby Doe recommendation for an Infant Care Review Committee (ICRC) as a check on newborn care has been endorsed by Department of Health and Human Services (HHS), The American Academy of Pediatrics (AAP), the American Hospital Association (AHA), and the American Medical Association (AMA). It appears this will be the beginning of addressing the entire subject of medical ethics with a committee structure.[4] A consensus of medicolegal experts at an American Society of Law and Medicine (ASLM) conference recommends hospitals form voluntary institutional ethics committees (IEC). Recommended issues to be covered are policies and guidelines of DNR orders, withholding or withdrawing treatment, consent and refusal to consent to treatment, rights of patients, and other sensitive topics.[5] It is interesting that although IEC is the current topic of interest, it was the first recommended in a legal document in 1976. This was in the New Jersey Supreme Court's opinion in In re Quinlan.[6] Thus the most widely known case in medical ethics has come full circle with the recommendation of the judge in the Quinlan case just today being widely accepted. The optimal protocol based on the survey and literature review is an ethics committee.

The next step in the development is to determine the scope of the committee. The survey addressed this issue by identifying the problem areas. They are: DNR orders, ordinary versus extraordinary treatment, need for hospice services, and demands to die. Cases in managing

terminally ill patients with these issues should be referred to this committee. The purpose of the ethics committee must be delineated. According to a report by Hospital Risk Management, April 1984, despite different views of what an ethics committee should do, experts overwhelmingly agree that this committee should not be the ultimate decision maker.[7] The final decisions should be made by the physicians and the patients.[8] The results of the internal survey indicated that the committee should be advisory only and include an educational role. The purpose of the ethics committee should be:

1. to recommend institutional policies concerning DNR orders, ordinary versus extraordinary treatment, and demands to die.

2. to provide guidance and advice in specific cases when decisions are made to DNR, withhold or withdraw treatment, and demands are made to die.

3. to coordinate and develop an ethical education program.

The next step is how to identify appropriate cases to be reviewed by the Ethics Committee. The issue of DNR orders is quite easy to identify. Any situation in which a DNR order is placed in a patient's chart must be referred to the Ethics Committee. All decisions to DNR should be written, thus no verbal or partial orders are to be given.[9] Decisions as to what constitutes ordinary or extraordinary treatment are more complex. The President's Commission recommends that these terms not be used because of the ambiguity created;[10] however, the key issue

involves the decision to withhold or withdraw life sustaining treatment. In this light, all cases involving terminally ill patients where the course of treatment or omission of treatment may cause death should be referred to this committee.

The issue of a need for hospice services does not directly involve the committee except for procedural guidance. The survey indicated that there is a need for hospice services in the larger hospitals. Perhaps if these services are not available within the community the Ethics Committee should address the creation of such services or alternatives. The issue is important because Army hospitals are normally not staffed or equipped to fulfill this need. Admission to hospice programs may amount to the decision to forego certain life-sustaining treatments, therefore, this issue must be addressed by the Ethics Committee.

The final issue is demands to die. This involves the right of the patient to refuse treatment, determinations of patient competency, living wills, and their legal implications. Certainly, the medical ramifications are in the domain of the physician; however, the physician cannot be aware of all the legal and moral issues that come into play with demand to die decisions. It is imperative that other professionals with the needed expertise be involved to aid the physician and patient in the decision making process. The Ethics Committee would bring to light other medical impacts and nonmedical ramifications involved on a case-by-case determination. Thus, in an effort to make the most informed decision possible, the Ethics Committee would aid

in identifying the impacting issues and offer its opinion or advice on them.

Committee Membership

The membership must include enough expertise in order to fulfill the committee's purposes. The purposes are to develop institutional policies, provide guidance on specific cases as they occur, and to coordinate ethical education programs. The results of the internal survey indicated that the committee should be composed of physicians, nurses, chaplains, social workers, and a legal representative. Administrators and lay representatives were not recommended. Based upon the results of the internal survey and the literature review, the following committee composition is recommended:

1. A Clinical Department Chief who desires to chair the committee.
2. Other physicians at the discretion of the chairman who have a particular expertise to add to the case being presented.
3. The patient's primary staff physician
4. Nursing representative
5. Chaplain
6. Social Worker
7. Legal Officer

It is important that the committee members desire to be on the committee and are not appointed merely to have a particular specialty

on the committee. The membership will vary according to the purpose being discussed. A policy or educational planning meeting probably will have a different composition than a meeting discussing a particular patient's case. The chairman will call a committee meeting as needed. Every health care provider may contact the chairman or other committee member to bring a particular case before the committee. Cases falling into the specifically outlined criteria must be referred to the committee. Education of the staff informing them of the Ethics Committee purposes and enforcing the criteria specifications must have command emphasis. The overall intent is for the committee to establish procedures to optimally aid the patient and the physician in the decision making process.

A model regulation for the function of an Ethics Committee is located in Appendix G. This protocol will have to be tested by actual cases and modifications made as new problems surface. WACH has started a monthly Ethics Conference for all interested health care providers and administrators to develop a higher ethical awareness of current problems and issues. Case studies are presented and the interests of the patient, family, provider, and society are discussed. Although there is rarely complete agreement or a final decision, by discussing the interests in the case with a multidisciplinary group, a more informed decision is made. Everyone who has participated in the conference has been surprised at the diverse opinions and has been exposed to perspectives that they had not considered. As a result of this project, a formal Ethics Committee will be established.

FOOTNOTES

[1]McNair, John N., "Survey of United States Army Physician Opinion: The Issue of Written Do Not Resuscitate," Graduate Research Project, Baylor University, August 1983.

[2]"Deciding to Forego Life-Sustaining Treatment," President's Commission for Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (Washington DC: US Government Printing Office, 1983), p. 254.

[3]Isaac, Stephen and Michael, William B., Handbook in Research and Evaluation, (San Diego, CA: Edits, 1981), pp 128-136.

[4]"Final Baby Doe Regs Push for New Review Committee," Hospital Risk Management, Vol 6, No. 4, p. 41.

[5]Ibid, p. 45.

[6]Robertson, John A., "Ethics Committees in Hospitals: Alternative Structures and Responsibilities," Quality Review Bulletin, Jan 84, p. 6.

[7]"Special Report: Institutional Ethics," Hospital Risk Management, p. 46.

[8]"Final Baby Doe Regs Push for New Review Committee," p. 45.

[9]Read, William Allan, "Hospital's Role in Resuscitation Decisions," Policy Development Study, (Chicago, IL: The Hospital Research and Educational Trust, 1983), p. 11.

[10]"Deciding to Forego Life-Sustaining Treatment," p. 89.

## III. CONCLUSION/RECOMMENDATIONS

### Conclusions

Ethical decision making is one of the most difficult issues facing hospitals today. As technology advances and consumer knowledge increases, ethical dilemmas will continue to proliferate. With people living longer and the cost of resources increasing, decisions as to who should receive them will be more difficult. Hospitals must be prepared to face these ethical dilemmas and devise workable processes to arrive at a decision that is medically, morally, legally, and socially justifiable. Army hospitals are not exempt from this responsibility. The survey and the literature review clearly indicated that ethical dilemmas regarding death and dying issues exist in Army and civilian hospitals. By studying the current literature and surveying selected Army hospitals, the optimal protocol for ethical decision making involving terminally ill patients was developed for Womack Army Community Hospital.

The problem areas as determined from the internal and external surveys are DNA orders, need for hospice services, ordinary versus extraordinary treatment, and demands to die. A comparison of problem areas with hospital size, level of awareness, current decision making protocols, rating of current protocols, and recommended optimal protocols gave insight into developing the optimal protocol for WACH. Hospitals responding with a low level of awareness in the survey indicated they had more problems. Larger hospitals have more difficulty with ethical

decision making than smaller hospitals. The only statistically significant conclusion was that the present protocol differed from the recommended optimal protocol. A written, formal decision making process is needed. Both the survey and the literature review point to the formation of an Ethics Committee.

A model regulation for the formation of an Ethics Committee is located in Appendix G. The purpose of the committee was determined from the internal and external surveys and the literature review. The problem areas in managing the terminally ill patient are the use of DNR orders, need for hospice services, ordinary versus extraordinary treatment, and demands to die. These issues must be addressed by the Ethics Committee. The physician and patient must make the ultimate decision as to the course of medical treatment. However, the hospital has the responsibility to ensure that the physician and the patient have all the needed information as to the different alternatives and their consequences. By having a systematic decision making procedure, the interests of the provider, the patient, and society will be considered before a decision is reached. An important role for the Ethics Committee is the coordination of an ethical education program to broaden the understanding of ethical dilemmas.

Recommendations

Based upon the results of this project, it is recommended that an Ethics Committee be formed at WACH. The purpose and functions of the committee are outlined in Appendix G. A multidisciplinary committee composition is essential to provide a complete review of the different interests involved. This includes expertise from other physicians, nurses, chaplains, social workers, and a legal officer. Cases to be reviewed by the committee must be clearly delineated and enforced. A comprehensive education program for the hospital staff must be coordinated through this committee. Members must have a desire to participate on the committee.

The recommendations are made for WACH and are concerned with managing terminally ill patients. Other ethical issues may be treated in a similar manner and at other Army hospitals. The key to a successful program is having a written, formal protocol that allows for a multi-disciplinary group to assist the patient and the physician in making the most informed decision possible.

# APPENDIX A

# DEFINITIONS

## APPENDIX A
## DEFINITIONS

Terminally Ill Patient: A patient is considered to be terminally ill if it is medically determined that he or she suffers from an irreversible disease process (or a combination of these) that bears a reasonable probability of directly causing the death of the patient in the foreseeable future.

Death and Dying Issues: For the purpose of this study, issues concerning death and dying are limited to DNR orders, ordinary versus extraordinary treatment, euthanasia, demands to die, and issues concerning hospice services.

Do Not Resuscitate (DNR) Order: This is an order, either written or unwritten, given by the physician to the hospital staff that specifies that a given patient will not be resuscitated if the need arises.

Ordinary versus Extraordinary Care: The distinction between ordinary/extraordinary care is as the difference between common and unusual care. Ordinary care is simple and extraordinary care is complex, elaborate, or artificial, or that employs elaborate technology and/or great efforts or expense.

Demands to Die: This deals with the patient's right to refuse treatment and be allowed to die. It encompasses living wills, informed consent, and competency of a patient.

# APPENDIX B

# INTERNAL SURVEY

APPENDIX B

INTERNAL ETHICS SURVEY
(Test Instrument)

The purpose of this survey is to gather perceptions of ethical issues and/or problems at Womack. Your honest responses/comments are requested to provide an accurate picture. Based upon the results from Womack, this survey will be modified and sent to other Army hospitals for their input. The ultimate goal is to assess the significance of ethical problems within Army hospitals and establish a methodology to successfully cope with them. Please complete the following questions and forward the completed survey to the Administrative Resident. Please comment on unclear questions or give ideas to improve the questionnaire.

1. My occupational area is: (Please circle)
   Physician
   Nurse
   Administrative
   Other (list) _____
   _____

2. I have read about or am familiar with the following ethical issues:

   I. Death and Dying

   | | | |
   |---|---|---|
   | --"No Codes" | YES | NO |
   | --"Ordinary" vs "extraordinary" treatment | YES | NO |
   | --Euthanasia | YES | NO |
   | --demands to die | YES | NO |

   II. Human Experimentation

   | | | |
   |---|---|---|
   | --Practicing on dying or dead individuals | YES | NO |
   | --Informing patients of double blind experiments | YES | NO |

   III. Issues in Reproduction

   | | | |
   |---|---|---|
   | --Caring for fetus after abortion | YES | NO |
   | --Genetic counseling | YES | NO |
   | --Sterilizing retarded children | YES | NO |

   IV. Allocation of Scarce Resources

   | | | |
   |---|---|---|
   | --Access to medical treatment | YES | NO |
   | --Prioritizing treatment | YES | NO |
   | --Forced transfer to other facilities | YES | NO |

3. I have experienced or know of actual cases involving the following ethical issues at Womack:

I. Death and Dying

| | | |
|---|---|---|
| --"No Codes" | YES | NO |
| --"Ordinary" vs "extraordinary" treatment | YES | NO |
| --Euthanasia | YES | NO |
| --Demands to die | YES | NO |
| --Other (Please list) _____ | | |
| _____ | | |

II. Human experimentation

| | | |
|---|---|---|
| --Practicing on dying or dead individuals | YES | NO |
| --Experiments using patients in double blind testing | YES | NO |
| --Other (Please list) _____ | | |
| _____ | | |

III. Issues in Reproduction

| | | |
|---|---|---|
| --Caring for fetus after abortion | YES | NO |
| --Genetic counseling | YES | NO |
| --Sterilizing retarded children | YES | NO |
| --Other (Please list) _____ | | |
| _____ | | |

IV. Allocation of Scarce Resources

| | | |
|---|---|---|
| --Access to medical treatment | YES | NO |
| --Prioritizing treatment | YES | NO |
| --Forced transfer to other facilities | YES | NO |
| --Other (Please list) _____ | | |
| _____ | | |

4. I have experienced or have knowledge of difficulty in managing patients involving the following ethical issues:

I. Death and Dying

| | | | |
|---|---|---|---|
| --"No Codes" | AGREE | UNDECIDED | DISAGREE |
| --"Ordinary" vs "extraordinary" treatment | AGREE | UNDECIDED | DISAGREE |
| --Euthanasia | AGREE | UNDECIDED | DISAGREE |
| --Demands to die | AGREE | UNDECIDED | DISAGREE |

4. (continued)

II. Human Experimentation

| | | | |
|---|---|---|---|
| --Practicing on dead individuals | AGREE | UNDECIDED | DISAGREE |
| --Experiments using patients in double blind testing | AGREE | UNDECIDED | DISAGREE |

III. Issues in Reproduction

| | | | |
|---|---|---|---|
| --Caring for fetus after abortion | AGREE | UNDECIDED | DISAGREE |
| --Genetic counseling | AGREE | UNDECIDED | DISAGREE |
| --Sterilizing retarded children | AGREE | UNDECIDED | DISAGREE |

IV. Allocation of Scarce Resources

| | | | |
|---|---|---|---|
| --Access to medical treatment | AGREE | UNDECIDED | DISAGREE |
| --Prioritizing treatment | AGREE | UNDECIDED | DISAGREE |
| --Forced transfer to other facilities | AGREE | UNDECIDED | DISAGREE |

5. I believe Womack handles the following ethical problems adequately:

I. Death and Dying

| | | | |
|---|---|---|---|
| --"No Codes" | AGREE | UNDECIDED | DISAGREE |
| --"Ordinary" vs "extraordinary" treatment | AGREE | UNDECIDED | DISAGREE |
| --Euthanasia | AGREE | UNDECIDED | DISAGREE |
| --Demands to die | AGREE | UNDECIDED | DISAGREE |

II. Human Experimentation

| | | | |
|---|---|---|---|
| --Practicing on dead individuals | AGREE | UNDECIDED | DISAGREE |
| --Experiments using patients in double blind testing | AGREE | UNDECIDED | DISAGREE |

III. Issues in Reproduction

| | | | |
|---|---|---|---|
| --Caring for fetus after abortion | AGREE | UNDECIDED | DISAGREE |
| --Genetic counseling | AGREE | UNDECIDED | DISAGREE |
| --Sterilizing retarded children | AGREE | UNDECIDED | DISAGREE |

IV. Allocation of Scarce Resources

| | | | |
|---|---|---|---|
| --Access to medical treatment | AGREE | UNDECIDED | DISAGREE |
| --Prioritizing treatment | AGREE | UNDECIDED | DISAGREE |
| --Forced transfer to other facilities | AGREE | UNDECIDED | DISAGREE |

6. Would a "committee" aid in managing ethical dilemmas? PROBABLY NOT YES DON'T KNOW

7. If a committee were established, what functions should it perform? (Check as many as appropriate):

Advisory Only _____
Decision Making _____
Counsel Family _____
Educate Staff _____
Other (Please list) _____

_____

8. If an Ethics Committee were formed, who should be members? (Check as many as appropriate):

Don't Know _____
Commander _____
Executive Officer _____
Other Physicians _____
Nurses _____
Chaplain _____
Social Workers _____
Lay Representatives _____
Administrators _____
Legal Officer _____
Others (Please List) _____

_____

PLEASE REMOVE YOUR NAME FROM SURVEY, FOLD AND STAPLE, AND RETURN TO THE ADMINISTRATIVE RESIDENT, CPT KOHLER, THROUGH DISTRIBUTION.

# APPENDIX C

# EXTERNAL SURVEY

APPENDIX C

ETHICS SURVEY ON DEATH AND DYING ISSUES

The purpose of this survey is to gather information concerning ethical decision making within Army hospitals. The ultimate goal of this project is to assess the prevalence of ethical problems related to death and dying and to establish a protocol to successfully manage them. Please complete the following questions and forward the completed survey to the Administrative Resident. Average completion time is three (3) minutes. For this project, death and dying issues are those concerned with managing terminally ill patients.

1. What is your position? _____ DCCS/CPS
_____ C Dept of Medicine
_____ Other (List) _____
_____
_____

2. What is the size of your hospital? Check one _____ Less than 50 beds
_____ 50-100 beds
_____ 100-200 beds
_____ 200-300 beds
_____ More than 300 beds

3. What is the level of awareness of ethical issues within your hospital concerning death and dying? Please check one
_____ Excellent
_____ Good
_____ Fair
_____ Poor
_____ Unsure

4. Does your hospital have a problem managing patients involved with the following death and dying issues? Circle appropriate response

| | | | |
|---|---|---|---|
| "no codes" | YES | NO | UNSURE |
| euthanasia | YES | NO | UNSURE |
| definition of death in your state | YES | NO | UNSURE |
| "ordinary" vs "extraordinary" treatment | YES | NO | UNSURE |
| need for hospice services | YES | NO | UNSURE |
| demands to die | YES | NO | UNSURE |



OVER

5. What is your current protocol for decision making involving death and dying issues.

_____ Interdepartmental committee

_____ Interhospital committee

_____ Ad hoc committee

_____ Written procedures

_____ Unwritten procedures

_____ None

_____ Other (Please list) _____

_____

_____

6. What rating would you give your hospital in managing patients involved with death and dying issues?

_____ Excellent

_____ Good

_____ Fair

_____ Poor

_____ Unsure

7. What do you think is the optimal protocol for decision making involving death and dying issues?

_____ Interdepartmental committee

_____ Interhospital committee

_____ Ad hoc committee

_____ Written procedures

_____ Unwritten procedures

_____ Other (please list) _____

_____

_____

8. Comments on ethical problems/decision making: _____

_____

_____

# APPENDIX D

# LETTERS OF INSTRUCTION

APPENDIX D

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT BRAGG, NORTH CAROLINA 28307

REPLY TO
ATTENTION OF: HSXC-XO

22 March 1984

SUBJECT: Survey of Ethical Issues

Chief, Clinical Support Division:

I am a graduate student in the Army-Baylor Program doing a study to complete my residency program. I am surveying all CONUS Army hospitals to assess the prevalence of ethical problems related to terminally ill patients and to establish a protocol to successfully manage them.

Inclosed are two short questionnaires (average completion time is 2 to 3 minutes). One is for the Deputy Commander for Clinical Services (DCCS/CPS) and the other for the Chief, Department of Medicine. Please give out the surveys to these individuals or their representatives if they are on leave or TDY and return them to me within a week if possible.

I know you are inundated with surveys, but your assistance is greatly appreciated. Thank you for your cooperation.

James C Kohler

JAMES C. KOHLER
CPT, MSC
Admin Resident, USA MEDDAC
Fort Bragg, NC 28307
AV 236-2906/6714

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT BRAGG, NORTH CAROLINA 28307

REPLY TO
ATTENTION OF: HSXC-XO

22 March 1983

SUBJECT: Survey of Ethical Issues

Fellow Administrative Resident:

Inclosed are two short questionnaires needed to complete my GRP. One is for the Deputy Commander for Clinical Services (DDCS/CPS) and the other for the Chief of the Department of Medicine. Please give the surveys to those individuals/their equivalents or their representative if they are on leave or TDY. Return the surveys to me within a week if possible. Average completion time is only 2-3 minutes. I know a lot of surveys are coming through you, but I would appreciate your assistance.

Again, thank you for your help and contact me if I can assist you.

James C. Kohler

JAMES C. KOHLER
CPT, MSC
Admin Resident
USA MEDDAC, Ft Bragg NC 28307
AV 236-2906/4802

# APPENDIX E

## HOSPITALS AND ADMINISTRATIVE RESIDENTS

APPENDIX E

| US ARMY MEDICAL CENTER | POINT OF CONTACT |
|---|---|
| Brooke, Fort Sam Houston, TX | MAJ Stanley Piotrowski |
| Dwight D. Eisenhower, Fort Gordon, GA | CPT George (Butch) Hammel |
| Fitzsimmons, Aurora, CO | MAJ Brian Foley |
| Letterman, San Francisco, CA | CPT Donald Bradley |
| Madigan, Fort Lewis, WA | MAJ Van Ride Booth |
| Tripler, Honolulu, HA | CPT George (Dan) Magee |
| Walter Reed, Washington, DC | CPT Paul Mouristen |
| William Beaumont, El Paso, TX | CPT Peter Basler |

| US ARMY COMMUNITY HOSPITALS | POINT OF CONTACT |
|---|---|
| DeWitt, Fort Belvoir, VA | CPT Jeanne Roberts |
| Martin, Fort Benning, GA | CPT John Becker |
| Womack, Fort Bragg, NC | CPT James Kohler |
| Florence B. Blanchard, Fort Campbell, KY | CPT Jim Sanders |
| US Army Hospital, Fort Carson, CO | CPT William Billingsley |
| Cutler, Fort Devens MA | CSD |
| Walson, Fort Dix, NJ | CSD |
| McDonald, Fort Eustis, VA | CSD |
| Darnall, Fort Hood, TX | CPT Lawrence Leahy |
| Raymond W. Bliss, Fort Huachuca | CSD |
| Moncrief, Fort Jackson, SC | CSD |
| Weed, Fort Irwin, CA | CSD |
| Ireland, Fort Knox, KY | CPT Paul Kiehl |
| Munson, Fort Leavenworth, KS | CSD |
| Kenner, Fort Lee, VA | CPT Michael Anders |
| General Leonard Wood, Fort Leonard Wood, MO | CPT William Lucas |
| Noble, Fort McClellan, AL | CSD |
| Kimbrough, Fort Meade, MD | CPT John Adams |
| Patterson, Fort Monmouth, NJ | CSD |
| Silas & Hays, Fort Ord, CA | CPT Leon Woodley |
| Bayne-Jones, Fort Polk, LA | MAJ Stephen White |
| Irwin, Fort Riley, KS | CPT Lee Briggs |
| Reynolds, Fort Sill, OK | MAJ Leonard Mosesman |
| Winn, Fort Steward, GA | MAJ James Rousey |
| Keller, West Point, NY | CPT Gene Fine |

# APPENDIX F

# RESULTS OF INTERNAL SURVEY

APPENDIX F
RESULTS OF INTERNAL SURVEY

| | | | |
|---|---|---|---|
| Question 1. | Occupational Specialty. | Physicians | 8 |
| | | Nurses | 2 |
| | | Admin | 4 |
| | | Other | 6 |

Question 2. Familiarity with the following ethical death and dying issues:

| | | |
|---|---|---|
| "No Codes" | 19 yes | 1 no |
| "Ord vs Extraord" | 20 yes | 0 no |
| Euthanasia | 20 yes | 0 no |
| Demands to Die | 19 yes | 1 no |

Question 5. Ethical problems at WACH:

| | Agree | Disagree | Undecided |
|---|---|---|---|
| "No Codes" | 6 | 6 | 8 |
| "Ord vs Extraord" | 7 | 4 | 9 |
| Euthanasia | 5 | 0 | 15 |
| Demands to Die | 5 | 2 | 13 |

Question 6. Need for an Ethics Committee:

12 Yes 4 No 4 Do Not Know

# APPENDIX G

## MODEL HOSPITAL COMMITTEE

APPENDIX G
Ethics Committee

1. PURPOSE. To aid the patient and physician in ethical decision making involving terminally ill patients through recognition of diverse value systems and legal implications.

2. FUNCTIONS.

a. To recommend institutional policies concerning DNR orders, ordinary versus extraordinary treatment, and demands to die.

b. To provide guidance and advice in specific cases when decisions are made to DNR, withhold or withdraw treatment, and demands to die are made.

c. To coordinate and develop an ethical education program.

3. COMPOSITION.

Clinical Department Chief desiring to chair the committee
Other physicians at the call of the Chairman
The patient's Primary Staff Physician
Nursing Representative
Chaplain
Social Worker
Legal Officer

4. MEETING FREQUENCY. Quarterly and as required by the Chairman.

5. MINUTES. The minutes of each meeting will be reviewed by the Medical Care Evaluation Committee and the Risk Manager.

6. AUTHORITY. MEDDAC Commander

# APPENDIX H

## NORTH CAROLINA RIGHT TO NATURAL DEATH: BRAIN DEATH AND 1983 AMENDMENTS

RIGHT TO NATURAL DEATH; BRAIN DEATH
and 1983 AMENDMENTS

Chapter 90-320. GENERAL PURPOSE OF ARTICLE.

NEW:
Section (a)

(a) The General Assembly recognizes as a matter of public policy that an individual's rights include the right to a peaceful and natural death and that a patient or his representative has the fundamental right to control the decisions relating to the rendering of his own medical care, including the decision to have extraordinary means withheld or withdrawn in instances of a terminal condition. This Article is to establish on optional and nonexclusive procedure by which a patient or his representative may exercise these rights.

(b) Nothing in this Article shall be construed to authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying. Nothing in this Article shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this Article are cumulative. (1977, c. 815; 1979, c. 715, s.1.)

## § 90-321. Right to a natural death.

(a) As used in this Article the term:
(1) "Declarant" means a person who has signed a declaration in accordance with subsection (c);
(2) "Extraordinary means" is defined as any medical procedure or intervention which in the judgment of the attending physician would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function;
(3) "Physician" means any person licensed to practice medicine under Article 1 of Chapter 90 of the laws of the State of North Carolina.

(b) If a person has declared, in accordance with subsection (c) below, a desire that his life not be prolonged by extraordinary means; and the declaration has not been revoked in accordance with subsection (e); and
(1) It is determined by the attending physician that the declarant's present condition is
a. Terminal; and
b. Incurable; and
(2) There is confirmation of the declarant's present condition as set out above in subdivision (b)(1) by a physician other than the attending physician;

then extraordinary means may be withheld or discontinued upon the direction and under the supervision of the attending physician.

(c) The attending physician may rely upon a signed, witnessed, dated and proved declaration:
(1) Which expresses a desire of the declarant that no extraordinary means be used to prolong his life if his condition is determined to be terminal and incurable; and
(2) Which states that the declarant is aware that the declaration authorizes a physician to withhold or discontinue the extraordinary means; and
(3) Which has been signed by the declarant in the presence of two witnesses who state that they (i) are not related within the third degree to the declarant or to the declarant's spouse and (ii) would not be entitled to any portion of the estate of the declarant upon his death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it then provided, and (iii) are not the attending physician, an employee of the attending physician or of a health facility in which the declarant is a patient, or of a nursing home or any group care home in which the declarant resides and (iv) is not a person who has a claim against any portion of the estate of the declarant at the time of the declaration; and
(4) Which has been proved before a clerk or assistant clerk of superior court, or a notary public who certifies substantially as set out in subsection (d) below.

(d) The following form is specifically determined to meet the requirements above:

"Declaration of A Desire For A Natural Death

"I....., being of sound mind, desire that my life not be prolonged by extraordinary means if my condition is determined to be terminal and incurable. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means.

"This the ..... day of ....., .....

Signature .....

"I hereby state that the declarant, ....., signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant, or as an heir under the Intestate Succession Act if the declarant died on this date without a will. I also state that I am not the declarant's attending physician or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group care home where the declarant resides. I further state that I do not now have any claim against the declarant.

Witness .....,
Witness ....."

The clerk or the assistant clerk, or a notary public may, upon proper proof, certify the declaration as follows:

"Certificate

"I, ....., Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for ..... County hereby certify that ..... and ....., witnesses, appeared before me and swore that they witnessed ....., declarant, sign the attached declaration; and also swore that at the time they witnessed the declaration (i) they were not related within the third degree to the declarant or to the declarant's spouse, and (ii) they would not be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending the declarant or an employee of an attending physician or of a health facility in which the declarant was a patient or of a nursing home or any group care home in which the declarant resided, and (iv) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration. This the ..... of ....., .....

.....
Clerk (Assistant Clerk) of Superior Court
or Notary Public (circle one as appropriate)
for the County of ....."

The above declaration may be proved by the clerk or the assistant clerk, or a notary public in the following manner:

(1) Upon the testimony of the two witnesses; or
(2) If the testimony of only one witness is available, then
   a. Upon the testimony of such witness, and
   b. Upon proof of the handwriting of the witness who is dead or whose testimony is otherwise unavailable, and
   c. Upon proof of the handwriting of the declarant, unless he signed by his mark; or upon proof of such other circumstances as will satisfy the clerk or assistant clerk of the superior court, or a notary public as to the genuineness and due execution of the declaration.

(3) If the testimony of none of the witnesses is available, such declaration may be proved by the clerk or assistant clerk, or a notary public
a. Upon proof of the handwriting of the two witnesses whose testimony is unavailable, and
b. Upon compliance with paragraph c of subdivision (2) above.

Due execution may be established, where the evidence required above is unavoidably lacking or inadequate, by testimony of other competent witnesses as to the requisite facts.

The testimony of a witness is unavailable within the meaning of this subsection when the witness is dead, out of the State, not to be found within the State, insane or otherwise incompetent, physically unable to testify or refuses to testify.

If the testimony of one or both of the witnesses is not available the clerk or the assistant clerk, or a notary public of superior court may, upon proper proof, certify the declaration as follows:

"Certificate

"I....., Clerk (Assistant Clerk) of Court for the Superior Court or Notary Public (circle one as appropriate) of..... County hereby certify that based upon the evidence before me I am satisfied as to the genuineness and due execution of the attached declaration by....., declarant, and that the declarant's signature was witnessed by....., and....., who at the time of the declaration met the qualifications of G.S. 90-321(c)(3).

"This the ..... day of....., .....

.....
Clerk (Assistant Clerk) of Superior Court
or Notary Public (circle one as
appropriate) for .....
County."

(e) The above declaration may be revoked by the declarant, in any manner by which he is able to communicate his intent to revoke, without regard to his mental or physical condition. Such revocation shall become effective only upon communication to the attending physician by the declarant or by an individual acting on behalf of the declarant.

(f) The execution and consummation of declarations made in accordance with subsection (c) shall not constitute suicide for any purpose.

(g) No person shall be required to sign a declaration in accordance with subsection (c) as a condition for becoming insured under any insurance contract or for receiving any medical treatment.

(h) The withholding or discontinuance of extraordinary means in accordance with this section shall not be considered the cause of death for any civil or criminal purposes nor shall it be considered unprofessional conduct. Any person, institution or facility against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose this section as a defense.

(i) Any certificate in the form provided by this section prior to July 1, 1979, shall continue to be valid. (1977, c. 815; 1979, c. 112; ss. 1-6.)

**Effect of Amendments.** — The 1979 amendment inserted "or a notary public" in subdivision (c)(4), inserted "or a notary public" following "clerk or the assistant clerk" throughout subsection (d), inserted "or Notary Public (circle one as appropriate)" in two places in each of the two certificates in subsection (d), and added subsection (i).

**Legal Periodicals.** — For a comment discussing North Carolina's Natural Death Act, see 14 Wake Forest L. Rev. 771 (1978).

For a survey of 1977 constitutional law, see 56 N.C.L. Rev. 943 (1978).

Chapter 90-322. PROCEDURES FOR NATURAL DEATH IN THE ABSENCE OF A DECLARATION.

(a) If a person is comatose and there is no reasonable possibility that he will return to a cognitive sapient state or is mentally incapacitated, and:

(1) It is determined by the attending physician that the person's present condition is:

a. Terminal; and
b. Incurable; and
c. Irreversible; and

(2) There is confirmation of the person's present condition as set out above in this subsection in writing by a physician other than the attending physician; and

NEW:

(3) A vital function of the person could be restored by extraordinary means or a vital function of the person is being sustained by extraordinary means;

then, extraordinary means may be withheld or discontinued in accordance with subsection (b).

(b) If a person's condition has been determined to meet the conditions set forth in subsection (a) and no instrument has been executed as provided in G.S. 90-321 the extraordinary means to prolong life may be withheld or discontinued upon the direction and under the supervision of the attending physician with the concurrence (i) of the person's spouse, or (ii) of a guardian of the person, or (iii) of a majority of the relatives of the first degree, in that order. If none of the above is available then at the discretion of the attending physician the extraordinary means may be withheld or discontinued upon the direction and under the supervision of the attending physician.

NEW:

NEW:

(c) Repealed by Session Laws 1979, c. 715, s. 2.

(d) The discontinuance of such extraordinary means shall not be considered the cause of death for any civil or criminal purpose nor shall it be considered unprofessional conduct. Any person, institution or facility against whom criminal or civil liability is asserted because of conduct in compliance with this section may interpose this section as a defense. (1977, c. 815; 1979, c. 715, s. 2.)

## § 90-323. Death; determination by physician.

The determination that a person is dead shall be made by a physician licensed to practice medicine applying ordinary and accepted standards of medical practice. Brain death, defined as irreversible cessation of total brain function, may be used as a sole basis for the determination that a person has died, particularly when brain death occurs in the presence of artificially maintained respiratory and circulatory functions. This specific recognition of brain death as a criterion of death of the person shall not preclude the use of other medically recognized criteria for determining whether and when a person has died. (1979, c. 715, s. 3.)